STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	00	COMPL	
		155632	B. WING			07/12/2	011
NAME OF D	ROVIDER OR SUPPLIER		S	TREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P.	NO VIDER OR SUPPLIER		7	23 E R	AMSEY RD		
	OF THE WABASH				NES, IN47591		
(X4) ID		TATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	17	AG	DEFICIENC!)		DATE
F0000							
	This visit was for	r the Investigation of	F0000	,	F0000Preparation and/or		
		r the Investigation of	10000	^U	execution of this Plan of		
	Complaint IN000	192333.			Correction does not constitut	е	
	G 1: DI00				admission or agreement by t		
	•	992333 - Substantiated.			Facility of the truth of the faci		
		iciencies related to the			alleged or conclusion set fort the Statement of Deficiencies		
	•	ted at F223, F225, and			The Plan of Correction is	٠.	
	F226.				prepared and/or executed so	lely	
					because it is required by the		
	Unrelated deficie	ency is cited.			law.Submissions of this		
					Response and Plan of Corre		
	Survey dates:				is not a legal admission that deficiency exists or that this	а	
	July 11 and 12, 2	011			Statement of Deficiency was		
					correctly cited and is also no		
	Facility number:	001138			be construed as an admissio		
	Provider number				against interest of the Facility		
	AIM number: 20				Administrator or any employed agents or other individuals w		
	7 HIVI Hamber: 20	0137070			draft or may be discussed in		
	Survey team:				Response and Plan of	0	
	Anne Marie Cray	ze DN			Correction. In addition,		
	Aille Marie Cray	/S KIN			preparation and submission		
	Communa la al 4				this Plan of Correction does		
	Census bed type:				constitute an admission or ar agreement of any kind by the		
	SNF/NF: 52				facility of the truth of any fact		
	Residential: 12				alleged or the correctness of		
	Total: 64				conclusions set forth in this		
					allegations by the survey		
	Census payor typ	e:			agency. This Plan of Correction shall constitute this facility's	וטו	
	Medicare: 5				credible allegation of complia	ince	
	Medicaid: 46				on or before August 11, 2011		
	Other: 13				-		
	Total: 64						
	Sample: 4						
I ARODATOD	V DIRECTOR'S OF BROW	TDER/SUPPLIER REPRESENTATIVE'S SIGN	IATIDE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AYXX11

Facility ID:

001138

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155632	B. WIN			07/12/2	011
	PROVIDER OR SUPPLIER			723 E R	ADDRESS, CITY, STATE, ZIP CODE RAMSEY RD NNES, IN47591		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ſΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0223 SS=D	findings cited in 16.2. Quality review 7/14. The resident has the verbal, sexual, physicorporal punishments seclusion. The facility must not sexual, or physical punishment, or inversidents facility failed to be remained free from abuse, in that she floor behind a nuresidents sample of 4. Resident A Findings include 1. On 7/11/11 at the of Nursing [DON "Fax/Incident Red Department of Horizontal Treport included," reported to the Department of Horizontal Treported	roluntary seclusion. ew and record review, the ensure a resident om mistreatment and e was secluded on the arses' station, for 1 of 4 d for abuse, in a sample 9:10 A.M., the Director N] provided a eport" to the Indiana State lealth, dated 6/16/11. The	F0	223	F223All staff training on the facility abuse prohibition and reporting policy was conduct May 23 and July 25, 2011.LF was immediately suspended pending investigation and terminated for failure to follow established facility policy. LF and all other staff present we counseled regarding facility pand reporting requirements. It was no evidence of harm to Resident A. Facility policies a protocols have been reviewe and are consistent with curre accepted standards of practice. The facility did cond an immediate and timely appropriate action was taken including immediate suspens and termination of LPN #1. In accordance with facility policithe law, the NHA or designed report allegations within 24 hof incident as appropriate. The NHA will randomly questions during daily rounds twice per	ed on PN #1 PN #3 Pre Poolicy There Ind Poolicy T	07/31/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155632		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 07/12/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE AMSEY RD INES, IN47591	1	- '
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IAU	remove [Residen and place her on central nurses stated described is oper staff to view. [QI that the first required [CNA # 3] was ig request from [LP that time [CNA # 1 laying said resided behind the nurses phoned [CNA # 3 occurrence, at that the incident states exactly the reported by [QM not feel good about only lasted for minutes, and there in her bed for sluth on the state of	the floor behind the ation. The area being a for all residents and MA#1] reports to DON test from [LPN#1] to genored. Upon second the floor se		IAU	week for six weeks and wee for four months regarding sta knowledge of misconduct definitions and reporting requirements. A recap of the facility safety policy will be p to staff at month meetings for following six months. The NH monitor for compliance and any negative finding to the CAssurance committee.	e rovide r the IA will report	DAIE

l	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER		723 E F	ADDRESS, CITY, STATE, ZIP CO RAMSEY RD NNES, IN47591	DE .	
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	indicated she told that." LPN # 2 in over, and as her a shift nurse were discussed that LI done that." LPN have said someth On 7/11/11 at 12 interview with Q she was working She indicated, "[won't lay still in nurses desk. The heard [LPN # 1] They were pickir laying her on the sitting on the flooked at [LPN # supervisor. Then QMA # 1 indicated approximately 10 her shift. QMA # the incident to the because she "tho QMA # 1 indicated sick to her stomatom of 7/11/11 at 1:0 with the DON, she came into my office."	d LPN # 1, "You can't do dicated her shift was and the other evening walking out, they PN # 1 "shouldn't have # 2 indicated, "We should hing." :05 P.M., during MA # 1, she indicated evening shift on 5/9/11. Resident A] sometimes bed. We sat her at the other shift came in. I tell an aide 'Help me.' hig [Resident A] up and floor. She was just or, and then laid over. I # 3] who was my I said, 'I'm out of here.'' ed this happened at 0:30 P.M., at the end of # 1 indicated she reported to DON 4 days later, high I would explode." ed the incident made her ch. 100 P.M., during interview he indicated, "[QMA # 1] fice on a Friday				
	something happe	as tearful. She said ned the previous Monday 10:25-10:30 P.M. She				

NAME OF PROVIDER OR SUPPLIER LODGE OF THE WABASH (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Said [LPN # 1] had come into work, and [Resident A] had been restless. [LPN # 1] told [CNA # 3] to 'Come here and help me. We are just going to lay her down on the floor." [CNA # 3] helped [LPN # 1] lay her on the floor." The DON indicated she immediately inserviced staff on abuse, gave written warnings, and terminated LPN # 1 after an investigation. On 7/11/11 at 1:20 P.M., during interview with LPN # 3, she indicated she with LPN # 3, she indicated she working evening shift on 5/9/11. She indicated Resident A was sitting in a wheelchair at the nurses desk, and LPN # 1 said, "Let's put her down on the floor." LPN # 3 at first just ignored her, but then LPN # 1 asked STREET ADDRESS, CITY, STATE, ZIP CODE		TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE	
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LPN # 3 indicated CNA # 3 at first just ignored her, but then LPN # 1 asked			· ·					
ignored her, but then LPN # 1 asked								
			·					
again, and she saw them put Resident A								
on the floor. LPN # 3 indicated someone			•					
got a mat and put it against the desk so								
Resident A could lean against the mat.		-						
LPN # 3 indicated, "Then [Resident A]			•					
just leaned down to the floor. She wasn't								
on a mat or anything. I don't think she								
even had a pillow. We were just shocked."		=	-					
LPN # 3 indicated her and LPN # 2 then		-	_					
left, and discussed the incident, and said,								
"This ain't right." LPN # 3 indicated that		· ·						
LPN # 1 was the 11-7 charge nurse, and								
they didn't want to question her. LPN # 3			•					
indicated, "She was totally wrong, and we		_	•					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
ANDILAN	OF CORRECTION	155632	A. BUI		00	07/12/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	2			RAMSEY RD		
LODGE	OF THE WABASH				NNES, IN47591		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		should have told	+	IAU	,		DATE
	someone."	Should have told					
	On 7/11/11 at 9:	30 A.M., the clinical					
	record of Reside	ent A was reviewed.					
	Diagnoses inclu	ded, but were not limited					
		Disease and Parkinson's					
	disease.						
	An admission M	[inimum Data Set [MDS]					
		ed 3/14/11, indicated the					
		a 5 out of 15 on cognitive					
		ndicating no memory					
		e MDS assessment					
	1 ^	ident required limited					
		o+ staff for transfer and					
		d not ambulate. A test for					
	· ·	Transitions and					
	_	ted the resident was "not					
	I -	e to stabilize with human					
	assistance" while	e moving from seated to					
	standing position	n, walking, turning					
	around, moving	on and off of the toilet,					
	_	urface transfer. The MDS					
	assessment indic	eated Resident A had					
	fallen since adm	ission and received one					
	injury.						
	2 On 7/11/11 or	t 10:40 A.M., the Director					
		ided the current facility					
		lent Safety Abuse					
	1 ^ -	sed 1/11. The policy					
	· ·	ose: It is the policy of our					
	_	ain a work and living					
	Lacinty to maint	and a work and hand					

PRINTED: 08/04/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	A. BUILDING B. WING	00	COMP 07/12/2	LETED
	PROVIDER OR SUPPLIER		723 E	T ADDRESS, CITY, STATE, ZIP (E RAMSEY RD ENNES, IN47591	CODE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	environment that from threat and/o harassment, abus mental or sexual punishment, invomisappropriation defined as the wing unreasonable corpunishment with or pain or mental the deprivation be including a caret that are necessary physical, mental well-beingInvodefined as separa other residents or	is professional and free or occurrence of se (verbal, physical, so, neglect, corporal pluntary seclusion and sof propertyAbuse is allful infliction of injury, of infinement, intimidation or resulting physical harm anguish. This includes				

001138

PRINTED: 08/04/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155632	B. WING		07/12/2011
	PROVIDER OR SUPPLIER		723 E R	DDRESS, CITY, STATE, ZIP CODE RAMSEY RD NNES, IN47591	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
F0225 SS=D	The facility must no have been found or mistreating resident have had a finding nurse aide registry mistreatment of resident of their property; a has of actions by a employee, which we service as a nurse the State nurse aide authorities. The facility must eviolations involving abuse, including ir and misappropriate reported immediate the facility and to with State law through (including to the Sagency). The facility must halleged violations and must prevent the investigation is the investigation is the reported to the adding representative and accordance with State survey and oworking days of the violation is verified action must be taken.	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or a entered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for aide or other facility staff to de registry or licensing Insure that all alleged guistreatment, neglect, or nijuries of unknown source ion of resident property are sely to the administrator of other officials in accordance ough established procedures tate survey and certification Insure that all alleged guistreatment, neglect, or nijuries of unknown source ion of resident property are sely to the administrator of other officials in accordance ough established procedures tate survey and certification Insure that all alleged guistreatment, neglect, or nijuries of unknown source ion of resident property are sely to the administrator of the administrator of the certification in the designated of the other officials in the state law (including to the certification agency) within 5 e incident, and if the alleged in appropriate corrective ien.			DATE OT/21/2011
	facility failed to abuse were report Administrator and	ew and record review, the ensure allegations of ted timely to the d State agency, in that esident A and staff did not	F0225	F225The facility does not emindividuals who have been for guilty of any form of mistreatment, nor does the facemploy any persons with neglindings on the nurse aide	ound

001138

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	
		155632	B. WIN			07/12/2	011
NAME OF	PROVIDER OR SUPPLIEF		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF	PROVIDER OR SUPPLIER			723 E F	RAMSEY RD		
	OF THE WABASH				NNES, IN47591		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	,		DATE
	1 *	nt to the Administrator			registry.All staff training on the facilty abuse prohibition and	ie	
	1	he incident was not			reporting policy was conduct	ed	
	1 -	tate agency for over 1			May 23 and July 25, 2011.LF		
	month, for 1 of	4 residents sampled for			was immediately suspended		
	allegations of ab	use, in a sample of 4.			pending investigation and		
	Resident A				terminated for failure to follow		
					established facility policy. Li and all other staff present we		
	Findings include	: :			counseled regarding facility		
					and reporting requirements.	-	
	1 On 7/11/11 at	9:10 A.M., the Director			was no evident harm to Resi		
	of Nursing [DOI	·			A. After subsequent review,	the	
	1				facility submitted a report		
		eport" to the Indiana State			summary to the State Depar		
	1 ^	Iealth, dated 6/16/11. The			of Health. Facility policies an protocols have been reviewe		
	1 -	"An incident was			and are consistent with curre		
	reported to the D	Director of Nursing			accepted standards of practi		
	Services on 05/1	3/2011 at approximately			The facility did conduct an		
	2:00 P.M. by [Q	MA # 1]. She reported			immediate investigation and		
	that on the eveni	ng of May 9th, 2001			timely, appropriated action w		
	[sic], at approxir	nately 10:30 P.M., [LPN			taken including the immediat		
		CNA # 3] to assist her to			suspension and termination LPN #1.In accordance with f		
	1 -	nt A] from her wheelchair			policy and law, the NHA or	aomity	
	I -	the floor behind the			designee will report allegatio	ns	
	1 -	ation. The area being			within 24 hours of the incide	nt as	
		n for all residents and			appropriate.The NHA will		
	1				randomly question staff durir daily rounds twice per week		
		MA # 1] reports to DON			six weeks and weekly for fou		
	1	uest from [LPN # 1] to			month regarding staff knowle		
	1	gnored. Upon second			of misconduct definitions and	-	
		PN # 1] to [CNA # 3] at			reporting requirements. A re		
	-	# 3] did assist her nurse in			of the facility safety policy wi	ll be	
	1 ' "	ent on the carpeted floor			provided to staff at monthly		
	behind the nurse	s work station. The DON			meetings for the following six months. The NHA will monito		
	phoned [CNA#	3] regarding this			compliance and report any	. 101	
	*	at time she confirmed			negative findings to the Qual	lity	
	1	actually did occur. She			Assurance committee.		

PRINTED: 08/04/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	(X2) MULTIPLE CO A. BUILDING B. WING	00	ľ	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		723 E F	ADDRESS, CITY, STATE, ZIP CO RAMSEY RD NNES, IN47591	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	reported by [QM not feel good about only lasted for minutes, and their in her bed for slur reporting is thirty incident of occur [quality assurance [interdisciplinary report this incide occurrence in an facility." On 7/11/11 at 10 interview with L was working ever # 2 indicated Resand was in and or indicated the ever Resident A in a way wheeled her to the approximately 10 indicated LPN # night shift nurse, to do this all night Resident A on the indicated she tole that." LPN # 2 in over, and as her a shift nurse were discussed that LI	PN # 2, she indicated she ning shift on 5/9/11. LPN sident A "had dementia, ut of bed." LPN # 2 ning staff had put wheelchair and had he nursing station at 0:30 P.M. LPN # 2 1 was the oncoming and said "I'm not going ht," and had her CNA put he floor. LPN # 2 d LPN # 1, "You can't do dicated her shift was and the other evening walking out, they PN # 1 "shouldn't have # 2 indicated, "We should				

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NAME OF PROVIDER OR SUPPLER LODGE OF THE WABASH INAME OF PROVIDER OR SUPPLER LODGE OF THE WABASH INAME OF PROVIDER OR SUPPLER INAME OF PROVIDER OR SUBMARY STATEMENT OF DEFICIENCIES INAME OF THE WABASH INAME OF PROVIDER OR SUBMARY STATEMENT OF DEFICIENCIES INAME OF THE WABASH INAME OF THE WASASH INAME OF THE WASAS	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155632		A. BUII	LDING	NSTRUCTION 00	COI	TE SURVEY MPLETED 2/2011	
T23 E RAMSEY RD			103002	B. WIN		DDPESS CITY STATE ZIPC		2/2011
SUMMARY STATEMENT OF DEFICIENCES ID RECORDSTRUCT ACTION SIGNED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION	NAME OF F	PROVIDER OR SUPPLIER					ODL	
REGULATORY OR LSC IDENTIFYING INFORMATION) On 7/11/11 at 12:05 P.M., during interview with QMA # 1, she indicated she was working evening shift on 5/9/11. She indicated, "Resident A] sometimes won't lay still in bed. We sat her at the nurses desk. The other shift came in. I heard [LPN # 1] tell an aide "Help me." They were picking [Resident A] up and laying her on the floor, and then laid over. I looked at [LPN # 3] who was my supervisor. Then I said, "Im out of here." QMA # 1 indicated this happened at approximately 10:30 P.M., at the end of her shift. QMA # 1 indicated she reported the incident to the DON 4 days later, because she "thought she would explode." QMA # 1 indicated the incident made her sick to her stomach. On 7/11/11 at 1:00 P.M., during interview with the DON, she indicated, "[QMA # 1] came into my office on a Friday afternoon, and was tearful. She said something happened the previous Monday at approximately 10:25-10:30 P.M. She said [LPN # 1] had come into work, and [Resident A] had been restless. [LPN # 1] told [CNA # 3] to 'come here and help me. We are just going to lay her down on the floor." The DON indicated she	LODGE	OF THE WABASH			VINCEN	INES, IN47591		
On 7/11/11 at 12:05 P.M., during interview with the DON 4 at paper days at approximately 10:30 P.M., at the end of her shift, OMA # 1 indicated the incident to the DON 4 days later, because she "thought she would explode." On 7/11/11 at 1:00 P.M., during interview with the DON, she indicated, "[CMA # 1] came into the or sick to her storach. On 7/11/11 at 1:00 P.M., during interview with the DON, she indicated this happened at approximately 10:30 P.M., at the end of her shift, OMA # 1 indicated the incident made her sick to her storach. On 7/11/11 at 1:00 P.M., during interview with the DON, she indicated, "[QMA # 1] came into my office on a Friday afternoon, and was tearful. She said (I.PN # 1] had come into work, and [Resident A] had been restless. [I.PN # 1] told [CNA # 3] to 'come here and help me. We are just going to lay her down on the floor." The DON indicated she					I			
On 7/11/11 at 12:05 P.M., during interview with QMA # 1, she indicated she was working evening shift on 5/9/11. She indicated, "[Resident A] sometimes won't lay still in bed. We sat her at the nurses desk. The other shift came in. 1 heard [LPN # 1] tell an aide 'Help me.' They were picking [Resident A] up and laying her on the floor. She was just sitting on the floor, and then laid over. 1 looked at [LPN # 3] who was my supervisor. Then I said, "I'm out of here." QMA # 1 indicated this happened at approximately 10:30 P.M., at the end of her shift. QMA # 1 indicated she reported the incident to the DON 4 days later, because she "thought she would explode." QMA # 1 indicated the incident made her sick to her stomach. On 7/11/11 at 1:00 P.M., during interview with the DON, she indicated, "[QMA # 1] came into my office on a Friday afternoon, and was tearful. She said something happened the previous Monday at approximately 10:25-10:30 P.M. She said [LPN # 1] had come into work, and [Resident A] had been restless. [LPN # 1] told [CNA # 3] to 'come here and help me. We are just going to lay her down on the floor." [CNA # 3] helped [LPN # 1] lay her on the floor." The DON indicated she		`			I	CROSS-REFERENCED TO THE		
immediately inserviced staff on abuse,	TAG	On 7/11/11 at 12 interview with Q she was working She indicated, "[won't lay still in nurses desk. The heard [LPN # 1] They were pickin laying her on the sitting on the floolooked at [LPN # supervisor. Then QMA # 1 indicat approximately 10 her shift. QMA # the incident to the because she "tho QMA # 1 indicat sick to her stoma On 7/11/11 at 1:0 with the DON, she came into my off afternoon, and w something happe at approximately said [LPN # 1] h [Resident A] had told [CNA # 3] to We are just going floor.' [CNA # 3] her on the floor.'	2:05 P.M., during MA # 1, she indicated evening shift on 5/9/11. Resident A] sometimes bed. We sat her at the other shift came in. I ttell an aide 'Help me.' ng [Resident A] up and floor. She was just or, and then laid over. I # 3] who was my I said, 'I'm out of here.''' ed this happened at 0:30 P.M., at the end of fl indicated she reported the DON 4 days later, ught she would explode.'' ed the incident made her och. 00 P.M., during interview the indicated, "[QMA # 1] fice on a Friday as tearful. She said as tearful. She said and the previous Monday 10:25-10:30 P.M. She ad come into work, and been restless. [LPN # 1] to 'come here and help me. ag to lay her down on the helped [LPN # 1] lay The DON indicated she		TAG			DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155632	A. BUI. B. WIN	LDING IG		07/12/2	011
NAME OF 1	PROVIDER OR SUPPLIER	" {	-	1	ADDRESS, CITY, STATE, ZIP CODE	!	
LODGE	OF THE WABASH			1	RAMSEY RD NNES, IN47591		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	WEO, 1147001		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE.	DATE
	l ~	rnings, and terminated					
	LPN # 1 after an	investigation.					
	On 7/11/11 at 1:	20 P.M., during interview					
		ne indicated she was					
	· ·	shift on 5/9/11. She					
		ft was almost over, and					
	"[Resident A] ha	d been up and down."					
	She indicated Re	esident A was sitting in a					
		e nurses desk, and LPN #					
		t her down on the floor."					
		ed CNA # 3 at first just					
	1	then LPN # 1 asked					
	"	nw them put Resident A					
		N # 3 indicated someone					
		t it against the desk so					
		l lean against the mat. ed, "Then [Resident A]					
		n to the floor. She wasn't					
	l *	hing. I don't think she					
		w. We were just shocked."					
		ed her and LPN # 2 then					
	left, and discusse	ed the incident, and said,					
	"This ain't right.	" LPN # 3 indicated that					
	LPN # 1 was the	11-7 charge nurse, and					
	they didn't want	to question her. LPN # 3					
	indicated, "She v	was totally wrong, and we					
	_	should have told					
	someone."						
	2 On 7/11/11 at	10:40 A.M., the Director					
		ded the current facility					
	• • •	lent Safety Abuse					
		sed 1/11. The policy					

PRINTED: 08/04/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	ľ í	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		723 E F	ADDRESS, CITY, STATE, ZIP CO RAMSEY RD NNES, IN47591	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	willful infliction confinement, int with resulting ph mental anguish, deprivation by at caretaker, of good necessary to atta mental and psych well-beingInvokefined as separated other residents of suspected, obsert of this resident suspected to the stand/or Administration immediately. but shall IMMEDIA's resident(s) and reviolations of this observationto the Administrator or designee will not the are the first of Administrator or determine if notificial to appropriate restate statute) or langencies"	pluntary seclusion is ation of a resident from r from his/her roomAny wed or reported violation afety policywill be apervisor and the DON rator per facility policy the supervisor on duty TELY safeguard the eport any alleged resident safety policy or the DON and/or designee. The DON or tify the Administrator if ontact. c. The designees shall fication should be made gulatory agencies (per				

Facility ID:

AND PLAN OF CORRECTION IDE		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 07/12/2	ETED
	PROVIDER OR SUPPLIER			723 E R	DDRESS, CITY, STATE, ZIP CODE AMSEY RD NNES, IN47591		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0226 SS=D	written policies and mistreatment, negrand misappropriated Based on intervior facility failed to a followed related allegations of about and State agency Resident A and sincident to the Adand the incident State agency for residents sampled in a sample of 4. Findings include 1. On 7/11/11 at of Nursing [DON "Fax/Incident Red Department of Horizont report included," reported to the Department of Horizont residents on 05/1, 2:00 P.M. by [QI that on the evening [sic], at approximus place her on central nurses states.	9:10 A.M., the Director I] provided a port" to the Indiana State ealth, dated 6/16/11. The	FO	2226	F 226The facility has developed and implemented written policated procedures that prohibit mistreatment, neglect and also fresidents. The facility does employ individuals who have been bound guilty of any formistreatment, nor does the facility and person with negating findings on the nurse aide registry. All staff training on the facility abuse prohibition and reporting policy was conduct May 23 and July 25, 2011. LF was immediately suspended pending investigation and terminated for failure to follow established facility policy. LF 3 and all other staff present we counseled regarding facility pand reporting requirements. The was no evident harm to Resing A. After subsequent review, facility submitted a report summary to the State Depart of Health. Facility policies are protocols have been reviewed and are consistent with current accepted standards of practice. The facility did conduct an immediate investigation and timely, appropriate action was taken including the immediate supension and termination of #1. In accordance with facility policy and the law, the NHA of designee will report allegation.	cies buse not n of acility ative ne ed on PN #1 v Pvere colicy here dent the the the the the the f LPN of	07/31/2011

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/12/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN47591				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	that the first required [CNA # 3] was ig request from [LP] that time [CNA # laying said reside behind the nurse phoned [CNA # 3] occurrence, at that the incident states exactly the reported by [QM] not feel good about only lasted for minutes, and their in her bed for slur reporting is thirty incident of occur [quality assurance [interdisciplinary report this incide occurrence in an facility." On 7/11/11 at 10 interview with L was working ever # 2 indicated Resident A in a wheeled her to the approximately 10 and the control of the control o	at time she confirmed actually did occur. She same facts previously A # 1] and adds she did out the situation, however approximately 20-30 in she placed said resident amber. As I am aware this y days past the actual rence, through the QA is process the IDT in team felt it important to ent to prevent possible alternate long term care		within the established time appropriate. The NHA will randomly question staff dur daily rounds twice per week six weeks and weekly for for months regarding staff known of miscondut definitions and immediate reporting requirements. A recap of the facility safety policy and regulidelines will be provided at monthly meetings for the following six months. The N monitor for compliance and any negative findings to the Quality Assurance committee.	ing c for our wledge d ne porting to staff HA will report		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP 07/12/2	LETED
	PROVIDER OR SUPPLIER		723 E R	ADDRESS, CITY, STATE, ZIP CODE RAMSEY RD NNES, IN47591	.	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	to do this all night Resident A on the indicated she tole that." LPN # 2 in over, and as her shift nurse were discussed that Lld done that." LPN have said someth On 7/11/11 at 12 interview with Q she was working She indicated, "[won't lay still in nurses desk. The heard [LPN # 1] They were picking laying her on the sitting on the flou looked at [LPN # supervisor. Then QMA # 1 indicated approximately 10 her shift. QMA # the incident to the because she "tho QMA # 1 indicated sick to her stomatom on 7/11/11 at 1:00 to the control of the stomatom of the st	d LPN # 1, "You can't do idicated her shift was and the other evening walking out, they PN # 1 "shouldn't have # 2 indicated, "We should hing." :05 P.M., during PMA # 1, she indicated evening shift on 5/9/11. Resident A] sometimes bed. We sat her at the other shift came in. I tell an aide 'Help me.' Ing [Resident A] up and Pfloor. She was just for, and then laid over. Ing aid, 'I'm out of here.'" ied this happened at 10:30 P.M., at the end of P.M., at the end of P.M. at the end of P.M. at the incident made her inch. Of P.M., during interview the indicated, "[QMA # 1]				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED 07/42/2014		
		155632	B. WING		07/12/2011
NAME OF I	PROVIDER OR SUPPLIER	\ \	l l	ADDRESS, CITY, STATE, ZIP CODE	
LODGE			l l	RAMSEY RD	
	OF THE WABASH			NNES, IN47591	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE
		ras tearful. She said			
		ened the previous Monday			
	- 11	10:25-10:30 P.M. She			
	1	ad come into work, and			
		been restless. [LPN # 1]			
	1	o 'come here and help me.			
	1 - 1	g to lay her down on the			
	, ,	helped [LPN # 1] lay			
		' The DON indicated she			
	immediately inse	erviced staff on abuse,			
	gave written warnings, and terminated				
	LPN # 1 after an investigation.				
	On 7/11/11 at 1:2	20 P.M., during interview			
	with LPN #3, sh	ne indicated she was			
	working evening	shift on 5/9/11. She			
	indicated her shi	ft was almost over, and			
	1	d been up and down."			
		esident A was sitting in a			
		e nurses desk, and LPN #			
	_	her down on the floor."			
		ed CNA # 3 at first just			
	1	then LPN # 1 asked			
	1 • '	w them put Resident A			
		N # 3 indicated someone			
	1 "	t it against the desk so			
		l lean against the mat.			
		ed, "Then [Resident A]			
	ľ	to the floor. She wasn't			
	I -	hing. I don't think she			
	_	v. We were just shocked."			
		ed her and LPN # 2 then			
		ed the incident, and said,			
	i "This ain't right."	" LPN # 3 indicated that			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155632	A. BUI	LDING	00	07/12/2	
		133032	B. WIN			07/12/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
LODGE	OF THE WABASH				RAMSEY RD NNES, IN47591		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
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TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	LPN # 1 was the	11-7 charge nurse, and					
	they didn't want	to question her. LPN # 3					
	indicated, "She w	vas totally wrong, and we					
	were wrong. We	should have told					
	someone."						
	2. On 7/11/11 at	10:40 A.M., the Director					
	of Nursing provi						
	policy on "Reside	ent Safety Abuse					
	Statement," revis						
	included: "Abu	ncluded: "Abuse is defined as the					
	willful infliction of injury, unreasonable						
	l '	midation or punishment					
		ysical harm or pain or					
	mental anguish.						
	1 ^	n individual, including a					
		ds or services that are					
	1	in or maintain physical,					
	mental and psych						
		luntary seclusion is					
	_	ation of a resident from					
		r from his/her roomAny					
	· '	ved or reported violation					
		afety policywill be					
	l -	ipervisor and the DON					
		ator per facility policy					
	l -	he supervisor on duty					
		ΓELY safeguard the					
	resident(s) and re						
		resident safety policy or					
	observationto t						
		designee. The DON or					
	1	rify the Administrator if					
	the are the first c	ontact. c. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	(X2) MULT A. BUILDI		STRUCTION 00	(X3) DATE S COMPL 07/12/2 0	ETED
		100002	B. WING		DDDGG GYRY GRUND GYR GODE	07/12/2	011
NAME OF F	ROVIDER OR SUPPLIER		- 1		DORESS, CITY, STATE, ZIP CODE		
	OF THE WABASH		_ \	VINCEN	NES, IN47591		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
F0323 SS=D	Administrator or determine if notice to appropriate restate statute) or languagencies"" This Federal tag IN00092333. 3.1-28(a) The facility must event environment remainstrates as is possible receives adequated devices to prevent Based on observative record review, the prevent Resident that alarms were supervision, for for falls, in a same Findings include 1. On 7/11/11 at was observed lying room. On 7/11/11 at 9:3 record of Resider Diagnoses included.	designees shall fication should be made gulatory agencies (per aw enforcement relates to Complaint relates to Complaint ins as free of accident sible; and each resident expervision and assistance accidents. ation, interview, and e facility failed to A from multiple falls, in used in place of I of 3 residents sampled aple of 4. Resident A	F032		F323The facility does strive to ensure that each resident receives adequate supervision and assistive devices to prevaccidents. Facility systems, policies and protocols have be reviewed and are appropriate MDS, care plan and fall historesident A will be reviewed a updated as necessary by Aug 11, 2011. The MDS nurse with ensure the nurse aide assignment sheets (care plan contain appropriate content. To Director of Nursing shall reviewed resident fall histories for the profour months. The MDS, care plans will be updated as necessary by August 11, 2011. The Administrator shall monitor for compliance by reviewing nursing notes, 24 histories for the province of the profour months.	on eent eeen e.The ry of and gust ill n) The ew past	08/11/2011

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632		(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/12/2011		
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN47591				
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE		
assessment, dated resident scored a status, with 15 in impairment. The indicated the resident sassistance of two toilet use, and did "Balance During Walking" indicated steady, only abled assistance" while standing position around, moving and surface-to-surface administration and surface administration in the standing position around, moving and surface-to-surface administration in the standing position around, moving and surface-to-surface administration in the standing position around, moving and surface-to-surface administration in the standing position around, moving and surface-to-surface administration in the standing position around, moving and surface-to-surface administration in the standing position around, moving and surface-to-surface administration in the standing position around, moving and surface-to-surface administration in the standing position around, moving and surface-to-surface administration in the standing position around, moving and surface-to-surface administration in the standing position around, moving and surface-to-surface administration in the standing position around, moving and surface-to-surface administration around, moving and surface-to-surface around	to stabilize with human a moving from seated to a, walking, turning on and off of the toilet, arface transfer. The MDS ated Resident A had assion and received one cluded the following A.M.: "Incident Type: or. Date of Incident: Incident: 10:35pm [sic]. ont's room. Resident's Confused Normal for at the Time: a Bruise: to LT [left]		report sheets and nurse aid assignment sheets three till week for eight weeks and variety for six months. Negative fill will be reported to the Qual Assurance committee. If negative outcomes are repile, incidents without immerinterventions, multiple inciders for one resident, the Admir will continue to monitor unt compliant with intervention supervision. Incidents are reviewed monthly during the Quality Assurance meeting Director of Nursing will revicare plans and care plan unfor the next four weeks to extend the set risk for falls have a plan in place. The Director Nursing shall review three week for the next two montained report negative findings to Quality Assurance committed.	mes a veekly ndings ity orted diate dents istrator il s and e s.The ew all pdates ensure a care of per ths and the		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	` ′	ESURVEY PLETED 2011
	PROVIDER OR SUPPLIER		723 E F	ADDRESS, CITY, STATE, ZIP CO RAMSEY RD NNES, IN47591	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	[resident] attemps since alarm put in able to get to result aroun [sic] in room supporting Internel helpful - it will confalls." 4/4/11 at 4:07 A. Observed on floom od/04/2011, Time [sic]. Location: In Resident's Conditionary at eye and cheek to emergency room of the eye and cheek to emergency room of the eye and who are in the eye and the eye and cheek are in the eye	wention: yes, alarm is ut down on some of the M.: "Incident Type: or. Date of Incident: 02:15AM Resident's room. tion Prior: Normal for y at the Time: from bed without y: Bruise: to left side face of, First Aid:Transferred omImmediate lemented: resident is ysical therapy] 3 times a with staff/has alarms for eelchair] constance [sic] help resident attempted of out of w/c after fall. porting Intervention: tored at all times without M.: "Incident Type: or. Date of Incident: 20:45PM				

		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00 COMPLETED 07/12/2011			
		155632	B. WIN			07/12/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
LODGE	OF THE WABASH			1	RAMSEY RD NNES, IN47591		
					NINES, IIN47391		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG			COMPLETION DATE
IAG			+	IAG			DATE
		at the Time: Sitting in					
	reclinerInjury: No apparent injury" 4/9/11 at 5:40 P.M.: "Incident Type:						
		or. Date of Incident:					
	•	e of Incident: 04:30PM					
	[sic]. Location: R						
	Resident's Condition Prior: Normal for						
	resident, Activity at the Time: Resident						
	had been laying in bedImmediate						
	Intervention Implemented: resident already has bed and chair alarm and						
		Assessment Supporting					
	Intervention: [lef	t blank]."					
	1/11/11 of 2:40 D	.M.: "Incident Type:					
		or. CNA went into room					
		ded and resident [sic] In knees stated she					
	_	eathroom. Location: Resident's Condition					
		Activity at the Time:					
	_	mediate Intervention					
	•	otion alarm mounted to					
		of incident: 04/11/2011,					
	Time of incident	. 09.10AWI.					
	4/27/11 at 10:45	P.M.: "Incident Type:					
		or. Date of Incident:					
		of Incident: 7:00PM.					
	·	end of 200 hall in the					
		esident's Condition Prior:					
		ent, Activity at the Time:					
	in wheelchairli	nmediate Intervention					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMP - 07/12/2	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN47591				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	Implemented: [left 5/3/11 at 2:12 P.: Observed on floot 05/03/2011, Time Location: Hallware Prior: Normal for Time: had stood without assistant and staff responds sounding Injury of back of head Implemented: result times, resident time of incident. intervention: [left 5/8/11 at 1:56 P.: Resident slid out Incident: 05/08/201:45PM. Locating Resident's Conditation asleep in value Time: sitting in value of the state	eft blank]." M.: "Incident Type: or. Date of Incident: of Incident: 01:30PM. ay. Resident's Condition or resident, Activity at the up from wheelchair ee, alarm was sounding led at time of alarm or. Skin tear; on right side or. Immediate Intervention sident has chair alarm at that been toileted at Assessment supporting		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE	1	
	Resident rolled of Incident: 05/16/2 04:13AM. Locat Resident's Conditactivity at the Title	A.M.: "Incident Type: but of bed. Date of 2011,Time of Incident: ion: Resident's room. tion Prior: sleeping, ime: resident stated she					
	was rolling over bed"	and slid off side of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
ANDILAN	or connection	155632	A. BUILI		00	07/12/2	
			B. WING		DDRESS, CITY, STATE, ZIP CODE		_
NAME OF I	PROVIDER OR SUPPLIER				AMSEY RD		
LODGE	OF THE WABASH				NES, IN47591		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
	5/10/11 at 0.11 A	M. "Incident Trace					
		A.M.: "Incident Type: or. Date of Incident:					
		of Incident: 07:29AM.					
	· ·	ay down 400 hall.					
		•					
		tion Prior: sleeping in resident, Activity at the					
	· ·	r resident, Activity at the chair Injury: Bruise:					
		chead right at hairline,					
	purple size of golf ball sizeCNA [name]						
	ran to alarm sounding, nurse [name] was						
	down hall"						
	5/19/11 at 10:55	A.M.: "Incident Type:					
		or. Date of Incident:					
		of Incident: 10:44AM.					
	·	ent's room Resident's					
		Normal for resident,					
		me: sleeping in bed"					
	Activity at the 11	me. steeping in bed					
	5/21/11 at 5:50 P	.M.: "Incident Type:					
	Witnessed fall. D	Date of Incident:					
	05/21/2011,Time	of Incident: 12:15PM.					
	Location: Dining	room . Resident's					
	Condition Prior:	Normal for resident,					
	Activity at the Ti	me: resident was being					
	taken into dining	room for lunch by					
	staffImmediate						
	Implemented: lap	buddy is to be on at all					
	1 -	er to straight back chair					
	in dining room."	-					
	5/27/11 at 3:17 A	A.M.: "Incident Type:					
	Observed on floo	or . Date of Incident:					

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Facility ID:

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
155632		B. WING 07/12/2011				011		
NAME OF I	PROVIDER OR SUPPLIER	= L			ADDRESS, CITY, STATE, ZIP CODE	-		
					RAMSEY RD			
LODGE OF THE WABASH				VINCE	NNES, IN47591			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
	1	e of Incident: 2:15AM.						
		ent's room . Resident's						
		Confused, Normal for						
	-	gnosis] Alzheimers.						
	1 *	ime: Transferring - res						
		_						
	1							
		•						
	1	•						
	1	103 2 3						
	_							
	1 2 3							
		-						
	mattress et still r	es climbs out of bed						
	when she wishes	- we have tried						
	everything within	n res's rights. res gets						
	aggitated [sic] ea	sily when unable to do						
	what she wants v	when she wants majority						
	of the x res wants to go home - unablr							
	[sic] to redirect r	es. has lap budy						
	[sic]cont to the best of our ability to							
	keep res safe - d/	t res's dx res will fall						
	again staff will g	et to res ASAP d/t sound						
	of alarm since res does not use call light thru the noc."							
	6/8/11 at 3:52 P.	M.: "Incident Type:						
	06/08/2011,Time	e of Incident: 2:45PM.						
	· ·							
	Condition Prior: Confused, Normal for resident. Activity at the Time: resident							
	[sic] to redirect res. has lap budy [sic]cont to the best of our ability to keep res safe - d/t res's dx res will fall again staff will get to res ASAP d/t sound of alarm since res does not use call light thru the noc." 6/8/11 at 3:52 P.M.: "Incident Type: Observed on floor . Date of Incident: 06/08/2011,Time of Incident: 2:45PM. Location: Resident's room . Resident's Condition Prior: Confused, Normal for							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155632		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 07/12/2011	
NAME OF PROVIDER OR SUPPLIER LODGE OF THE WABASH			STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN47591				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	selfImmediate Implemented: reand given a snac she did not need resident currently alarm. Chair alar functioning at tir A Care Plan, date 6/13/11, indicate for Trauma-Falls cognitive status, used, Unsteady g status, Incontine by History of fal Impaired sense of The approaches ask for assistance Call light in react plan3-14-11 Be applied3-20-11 staff. 4-11 Increase medication] R/T restlessnesslow alarm, position/thelp keep resident On 7/11/11 at 11 observed sitting activity room. She An activity was at table, with two a	sident up in wheelchair, k per her request. stated to be toileted at that time. It was a bed and chair m was on and me of incident" ed 3/4/11 and updated d a problem of "Potential related to: Decline in Appliance or device gait, Decline in functional mee, Dementia manifested ls, Use of psychotropics, of balance, Unsteady gait." included: "Encourage to e, Monitor closely, h3-7-11 Begin toileting ed alarm Chair alarm to alert use Xanax [anti-anxiety					

i '		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	A. BUILDING 00		СОМРІ	X3) DATE SURVEY COMPLETED 07/12/2011		
NAME OF PROVIDER OR SUPPLIER LODGE OF THE WABASH			B. WING OFFIZIZOFF STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN47591					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	table, but was away from the activity facing a television. On 7/11/11 at 11:45 A.M., Resident A was observed sitting in the activity room. No staff were present. A staff member was observed to be wheeling residents to the dining room. On 7/11/11 at 1:00 P.M., during interview with the Director of Nursing, she indicated Resident A had a cervical curvature, and "could just fall right out of her chair." On 7/11/11 at 2:00 P.M., during interview with the Administrator, she indicated the resident had not fallen since June, when they obtained the "new chair."							
	of Nursing provided policy on "Fall A Protocol," revised included: "Purposite action prevent and reduct the resident care intervention(s) to trends or patterns through the facilities.	9:45 A.M., the Director ded the current facility assessment & Prevention d 6/11. The policy se: To ensure the ns are taken to assess, ce resident fallsUpdate plan with the appropriate be keep resident safeAny in falls will be evaluated ity Quality Assurance athly/quarterly basis"						
	3.1-45(a)(2)							

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	A. BUILDING B. WING	00	COMP 07/12/2	LETED		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
LODGE OF THE WABASH			723 E RAMSEY RD VINCENNES, IN47591					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION D BE OPRIATE	(X5) COMPLETION DATE		